State Kentucky

NURSING FACILITY REIMBURSEMENT - METHODS AND PROCEDURES
FOR OCTOBER 1, 1990 AND THEREAFTER

The following sections summarize the methods and procedures for determining nursing facility rates in Kentucky.

Participation Requirements

Nursing facilities currently participating as skilled nursing or intermediate care facilities will be required to participate in the program as a nursing facility (NF) effective October 1, 1990 (the effective date of this change pursuant to OBRA 87). To participate in the Medicaid Program, the facilities will be required to be licensed as nursing facilities (not SNF or ICF) at the time of the first annual survey by the state survey agency which occurs on or after October 1, 1990; at that time, multilevel Medicaid nursing homes will not be recognized, as all nursing care beds in a facility will be considered a part of the same facility. Hospitals providing swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. Hospitals providing dual licensed nursing facility care shall be required to be dually licensed as hospital/nursing facility unless such licensure is not permitted under state licensing statutes; if NF licensure is not permitted by statute, the hospital-SNF/ICF licensure may continue to be used. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare). Any Medicare participating NF may take high intensity care (Medicare skilled nursing care equivalent) and/or low intensity care (the former ICF care equivalent) patients; NFs with a waiver of the nursing requirement (i.e., non-Medicare participating NFs) may take only low intensity patients since the facility is not considered as being adequately staffed to care for high intensity care patients. In the interim (until facilities are surveyed), current skilled nursing facilities participating in Medicare may accept both high and low intensity patients. Current intermediate care facilities not participating in Medicare may accept low intensity patients.

Cost Finding and Cost Reporting

1. Facilities submit cost reports each year. The single state agency uses the latest cost report available on May 15th preceding the rate year with prospective rates based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. Costs are trended to the beginning of the rate year (July 1 of each year) and indexed for inflation using the Data Resources, Inc. inflation index. Facilities use a uniform cost reporting form.

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2. The single state agency will modify the cost report form to provide for the distinct cost categories necessary to match with the nursing assessment data for case mix implementation.

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. At least 15 percent of the facilities will be field audited each year using generally accepted accounting principles. Costs will be limited to those costs found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Allowable Costs

Allowable costs are costs found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed. A cost savings incentive return is a part of allowable cost.

Methods and Standards for Determining Reasonable Cost-Related Payments

1. The methods and standards for the determination of reimbursement rates to nursing facilities and intermediate care facilities for the mentally retarded is as described in the Nursing Facility Reimbursement Manual which is to be included as Attachment 4.19-D, Exhibit B.

2. Payment Rates Resulting from Methods and Standards

   Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

3. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Data Resources, Inc. inflation index.

4. Rates are established prospectively at the beginning of each quarter during the rate year (January, April, July, and October) and will not be adjusted except for mandated cost changes resulting from government actions, to accommodate changes of circumstances affecting patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), and to adjust to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.

5. The following special classes of nursing facilities are recognized in the Medicaid Program.

   a. Hospital based nursing facilities are nursing facilities based in hospitals.

   b. Dual licensed pediatric facilities are nursing facilities serving predominantly children who provide both high intensity and low intensity nursing services.

   c. NFs with Mental Retardation Specialty (NF/MRSs) are nursing facilities (not including ICF-MRs) with a patient care load including at least fifty-five percent mentally retarded individuals.

   d. Swing-bed facilities are those hospitals with designated swing-bed units providing nursing facility care in the Medicaid Program in accordance with the swing-bed requirements shown in Title XVIII and Title XIV of the Social Security Act.

   e. Dual-licensed hospital bed facilities means nursing facility care provided in hospital beds participating in the Medicaid Program as nursing facility beds.

   f. NF/Institutions for Mental Diseases means those facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.

   g. NF/Head Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, providing care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization such as the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide specialized rehabilitation services.

h. NF/Ventilator Dependent means NFs that prior to July 1, 1985 had a bona fide ventilator therapy program with at least ten (10) patients being served.

6. Case mix assessments are performed in accordance with Attachment 4.19-D, Exhibit A (see attached).

7. Effective October 1, 1990 and continuing until the costs are reflected in the cost reports, the single state agency will add-on an amount to the prospectively determined rates to reimburse for cost incurred to implement the requirements of OBRA 87 as described in Exhibit A.

8. In order to provide for transition to a single level of care and the case mix assessment and payment system, there will be a "hold harmless" period from October 1, 1990 through June 30, 1992, as described in Exhibit A.

9. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment. Payments shall be made without comparison to usual and customary or actual billed charges of the provider on a per diem, annual, aggregate or other basis.

10. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

11. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

12. Payments will be made by Title XIX (Medicaid) for skilled nursing care for an amount equal to that applicable to Medicare Part A coinsurance amount for the twenty-first through 100th day of skilled nursing care for patients who are eligible for Part A Medicare and admitted to an approved Medicare facility under conditions payable by Medicare.

13. Effective July 15, 1994, facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all-inclusive (excluding drugs) negotiated rate which shall not exceed the facilities' usual and customary charges.

Cost Related to Nursing Home Reform Requirements
From October 1, 1991 to September 30, 1992

The state attributes the following costs to nursing facility reform when the costs were added to the rates to meet nursing home reform related costs as an add-on, or when the cost of a change was attributed to nursing facility reform and would not have been incurred except for nursing facility reform; in the case of add-on costs absorbed into the cost base, the state would deduct any add-ons not shown in the cost base.

The following are nursing facility reform costs:

A. The state is paying an add-on of $1.38 per day to the facility's rate for universal precautions and infection control.

B. The state is paying an add-on of 38 cents per day to the facility's rate to cover the indirect cost associated with nurse aide training. Direct costs are billed to the state as an administrative cost.

C. The single level of care requirement has been accomplished through the implementation and approval of the Case Mix Reimbursement System (Attachment 4.19-D, Exhibit A in current state plan), at a cost of $1.70 per day.

D. The following additional amounts have been added through OBRA related interim rate change requests:

(1)	Increased nursing staff ($2.1 million annually)	.36 per day
(2)	Medical Director Costs ($71,000 annually)	.01 per day
(3)	Social Worker costs ($180,000 annually)	.03 per day
(4)	Resident's Rights ($115,000 annually)	.02 per day
(5)	Restraint free environment ($71,000 annually)	.01 per day

(6)	Other OBRA Related Requirements ($110,000 annually)	.02 per day
(7)	Maintaining maximum quality of life (met by compliance with program requirements)	.00 per day

BRAIN INJURY FACILITY
NEUROBEHAVIORAL PROGRAM
RATE NEGOTIATION

When it is necessary for a Kentucky Medicaid recipient to be placed in a brain injury facility which offers a neurobehavioral program, an all-inclusive per diem rate is negotiated one-on-one with the facility. Medicaid staff first inquires about the rate schedule of the individual facility to determine whether there is a Medicaid rate in effect for that state's recipients and whether discounts are available for insurers if the facility does not participate in its state's Medicaid Program. Medicaid staff would accept the rate offered by the facility if it were $510 per diem or less (the standard out-of-state per diem of $360 plus $150 per diem for the neurobehavioral program). If the facility's offer exceeded this amount, Medicaid staff would offer the $510 per diem.

Kentucky has enrolled only one such facility as of February 1, 1995.

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COSTS RELATED TO NURSING FACILITY REFORM

October 1, 1997

The state attributes the following costs to nursing facilities' compliance with the Omnibus Budget Reconciliation Acts (OBRA) of 1987 and 1990.

(1) The following amounts are included in the cost report used to set the facilities' rates:

A.	Costs associated with universal precautions and infection control	$1.38 per day
B.	Indirect cost associated with nurse aide training	$ .38 per day
C.	Increased nursing staff	$2.85 per day
D.	Dietician costs	$ .03 per day
E.	Medical director costs	$ .03 per day
F.	Pharmacy costs	$ .01 per day
G.	Social worker costs	$ .06 per day
H.	Resident's rights	$ .05 per day
I.	Restraint free environment	$ .01 per day
J.	Other OBRA related requirements	$ .03 per day
K.	Maintaining maximum quality of life (met by compliance with program requirements)	$ .00 per day

(2) The single level of care requirement has been accomplished through the implementation and approval of the Case Mix Reimbursement System (Attachment 4.19-D, Exhibit A in current state plan), at a cost of $1.70 per day.

Reimbursement Methodology for State Fiscal Year 1998-1999 and State Fiscal Year 1999-2000.

1. Rates for nursing facilities and nursing facilities designated as mental retardation specialty for the rate year beginning July 1, 1998, and ending June 30, 1999, and for the rate year beginning July 1, 1999, and ending June 30, 2000, shall be determined by using a rate on rate methodology.

   a. The rate of increase over a facility's June 30, 1998, rate shall be 5.8 percent for state fiscal year 1998-1999. This rate of increase is determined by an analysis of current rates, utilization, patient liability, and historical rates of increase as subjected to a $519.1 million annual budget.
   b. The rate of increase over a facility's June 30, 1999, rate shall be at a minimum 3.0 percent for state fiscal year 1999-2000. This rate of increase is established to achieve a rate increase that shall not cause total payments to nursing facilities to exceed budgeted funds of $534.6 million for that fiscal year based upon static utilization of beds.

2. The Department shall remain at risk for increases in total nursing facility payments which result from higher utilization of beds by Medicaid recipients.

3. The calculated rate shall be determined as follows:
   a. The department shall use a facility's June 30, 1998, lessor of actual or maximum nursing cost per case mix unit.
   b. This unit shall be multiplied by the department's approved facility case mix average for the quarter being calculated.
   c. To this product shall be added the facility's June 30, 1998, cost savings incentive per diem as described in 4.19-D, Exhibit B, page 106.01.
   d. The department's approved "all other costs" per diem rate as described in 4.19-D, Exhibit B, page 102.02, shall be added to the sum calculated above.
   e. The sum derived above shall be multiplied by the rate of increase as specified in 1 a. and 1 b. above.
   f. Capital Costs and other approved add-ons shall be added to the above calculations to determine the final facility rate.

      i. Capital costs shall be based upon a calculation of a new maximum allowable basis of depreciation expense and allowable financing to be used in future reimbursements of capital expense due to the acquisition of additional property by a facility.

      ii. Other approved add-ons shall include those increases in costs due to governmentally imposed wage increases, new licensure requirements or new

interpretations of existing requirements by the appropriate governmental agency as issued in administrative regulations, written policy which effects all facilities within a class, or other governmental action which results in an unforeseen cost increase.

4. A case mix adjustment shall be the only adjustment made to the rates by the department.

5. Other adjustments shall not be made to the rates except for errors identified by the department when computing the rate.

6. The following facilities shall be excluded from the above rate setting methodology but shall be included in the budgeted limits:
   a. A nursing facility with a certified brain injury unit;
   b. A nursing facility with a distinct part ventilator unit;
   c. A nursing facility designated as an institution for mental diseases;
   d. A pediatric nursing facility;
   e. An intermediate care facility for the mentally retarded.

7. The rate for newly participating facilities shall be 115 percent of the median payment of the appropriate urban or rural array.